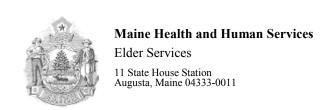
TTY: (888)720-1925



## MAINECARE HOME HEALTH PAYMENT RESEARCH FORM

Date:	
Home Health Agency:	Contact Person:
Address:	
	Fav #
Member Name:	
MaineCare #:	SS #:
1. Initial Certification Payment Issues	
Start of Care Date:Admit/Discharge sent:	to
2. Prior Authorization Payment Issues	
Prior Authorized Period: From Referral Date:	
Assessment Date:  Payment Dates in Question:  Disciplines billing for:  Explain Problem:	to
Please submit copies of the start of care, adn support your request. DO NOT send copies	nit/discharge form and other pertinent information to of rejected claims. Fax to 287-9231.
3. OES Response  ☐ No admit/discharge on file. Please submit ☐ PA required for this discipline. Please mal ☐ No Section 17 document for exemption rec ☐ Other	ke a referral to Goold for prior authorization. ceived. Please submit Section 17.
Office of Elder Services 442 Civic Center Drive	Toll Free: (800)262-2232 Fax: (207)287-9229

Augusta, Maine 04333-0011